**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**
***CONTRACT AMENDMENT REQUEST FORM OF INDIVIDUAL REHABILITATION SUPPORTS***

***MR/RD_____ Autism_____ HASCI____***

| PLEASE TYPE OR PRINT | |
|---|---|
| Provider: | Date: |

**PROPOSED ACTION:** ***(check one)***

☐ Replace individual no longer receiving/needing services. (No new units or funding)

☐ Increase number of individuals with additional units and funding.

**PROPOSED EFFECTIVE DATE FOR ABOVE REQUESTED ACTION:**

| **CONSUMER INFORMATION** | |
|---|---|
| Name of Individual no longer receiving/needing services: | |
| Social Security Number: | Termination Date from Service: |
| Name of individual wishing to receive/replace services: | |
| Social Security Number: | Medicaid #: |
| Is Individual Currently Medicaid eligible? Yes☐ No☐ | Effective date for Medicaid eligible: |

***JUSTIFICATION:***

**Are 250 units available to each person added to this contract? ☐ YES ☐ NO**

*(If "No" is marked, explain the circumstance and number of units needed to provide each person with 250 units in the next 12 months)*

Signature: _____ Date: _____

*(Executive Director*

The proposed number of individuals to be served must be the cumulative number of different individuals to be served under the Contract during the contract period. Each person has up to 250 units available to them in 12 months after the services begin date.

**The completed form, signed and dated is forwarded to the appropriate Central Office Division for processing.**

*IRS Form 5*